FILE COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

January 22, 2008

Robin Wallis
MultiCare Home Health Services
P.O. Box 355
Meridian, Idaho 83680

Dear Ms. Wallis:

This is to advise you of the findings of the Medicare survey at MultiCare Home Health Services which was concluded on January 11, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 4, 2008**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

por

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw

Enclosures

MULTICARE
Home Health

"Caring
From
The Heart"

RECEIVED
FEB 0 1 2008
FACILITY STANDARDS

January 31, 2008

Gary Guiles and/or Sylvia Creswell
Department of Health & Welfare
Bureau of Facility Standards
3232 Elder Street
PO Box 83720
Boise, ID 83720

Dear Mr. Guiles,

Enclosed, please find MultiCare Home Health's response to our January 11, 2008 survey. We have addressed each deficiency and handled according to the specifications outlined in the cover sheet of the review.

We appreciate the review and feedback which allows MultiCare Home Health to correct, improve and create new processes to promote great home health care services.

Let me know if you have any questions or concerns.

Sincerely,

Lori Page, RN
Director of Clinical Services

Cc: Sharon Anitok
Cc: Cherie Goers
Cc: Robin Wallis

Tel: (208) 884-5497
Fax: (208) 887-7727
324 S. Meridian Rd, Suite 14
P.O.Box 355, Meridian, Idaho 83680

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137093	A. BUILDING _____ B. WING _____	01/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICARE HOME HEALTH SERVICES, INC	324 S MERIDIAN RD SUITE 10 MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency. The surveyor conducting the recertification visit was Gary Guiles, RN, HFS. Acronyms used in this report include: CMS = Centers for Medicare and Medicaid DNS = Director of Nursing Services LPN = Licensed Practical Nurse POC = Plan of Care RN = Registered Nurse SOC = Start of Care	G 000	RECEIVED FEB 01 2008 FACILITY STANDARDS	
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure documentation of effective interchange, reporting, and coordination of patient care had occurred for 3 of 8 patients (#s 3, 6 and 7), who had received multiple services. The findings include: 1. Patient #3 was a 74 year old male with a SOC date of 12/10/07. He was currently a patient as of 1/10/08. His diagnosis was multiple sclerosis. A physician update written by the nurse, dated 12/20/07, stated "I know that (the patient's spouse) has been very overwhelmed during this time, and have tried to help her as much as	G 144	G144 Case conferencing and appropriate interchange between Nurses, Therapists, Physicians, Social Workers and Home Health Aides will occur on a regular basis and documented at least every two (2) weeks, including more frequently as needed, based on Patient's needs. The Director of Clinical Services and the Nurse Case Manager of the Patient will provide appropriate documentation and monitor when documentation is turned in every two (2) weeks and as necessary. This will be completed by 01-Feb-08.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: DNS — (X6) DATE: 1/31/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 144	Continued From page 1 possible during our visits. We are trying to get all of the services in place, with the information that we are getting from the family. I would like to send out a social worker to see if there are resources in the community they can access. I am concerned for (the spouse) and the strain she is under." Social Work visits were made on 12/19/07 and 12/26/07. The patient's record did not document coordination of care between the nurse and the social worker. The social worker was interviewed on 1/9/08 at 2:40 PM. The DNS was interviewed on 1/10/08 at 3 PM. Both stated they spoke regarding the patient's care but did not document the interchanges. 2. Patient #6 was a 49 year old female with a SOC date of 5/11/07. Her diagnoses were diabetes and decubitus ulcer. She had an above the knee amputation and a history of skin breakdown. She was currently a patient as of 1/10/08. A physician update by the nurse, dated 11/5/07, stated "We are continuing treating the wounds/impaired skin, per wound clinic orders, and they are trying to heal. (The patient and spouse) have gone back to poor diet, not positioning her or getting her up and out of bed for more time than the PCS provider is in the home (approximately 2 hours). This has been discussed with (the patient and spouse) and they have also been informed that if they do not start following the care needs that she needs...this will be the last home health episode that she will receive from us." A social worker saw the patient on 11/16/07 and 11/27/07. The social service evaluation on 11/16/07 stated "Pt has a (history) of poor compliance with treatment, meds & diet...Pt also has a (mental illness)-bipolar disorder, but denies any current symptoms or challenges managing the (mental illness)." The	G 144		

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G 144	Continued From page 2 patient's record did not document coordination of care between the nurse and the social worker. The social worker was interviewed on 1/9/08 at 2:40 PM. The DNS was interviewed on 1/10/08 at 3 PM. Both stated they spoke regarding the patient's care but did not document the interchanges. 3. Patient #7 was a 78 year old male with diagnoses of congestive heart failure and diabetes. His SOC was 7/10/06. He was discharged on 7/10/07. On 5/14/07, he fell and sustained fractures of both legs. The fractures were splinted with braces and the patient returned home on bedrest. The record documented the patient had skin breakdown due to the braces. He also suffered pain from the fractures. The agency obtained orders and took measures to decrease the patients pain and skin breakdown. However, the POC was not changed to address pain control and skin breakdown. The POC for the certification period 7/5/07-9/2/07 did not address these items. Also, after the fall, the patient's spouse became distraught and emotionally fragile. The case manager, interviewed on 1/9/08 at 3:30 PM, stated the spouse was very volatile. She said at times she spent 2 hours in the home because the spouse needed to "vent and cry". The social worker visited the patient and spouse on 5/30 and 6/8/07. The patient's record did not document coordination of care between the nurse and the social worker. The social worker was interviewed on 1/9/08 at 2:40 PM. Both the case manager and the social worker stated they spoke regarding the patient's care but did not document the interchanges.	G 144		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 158		

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G 158	Continued From page 3 Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on review of patient records and agency policies and staff interview, it was determined the agency failed to ensure that care followed a written plan of care established by a physician for 4 of 11 patients (#s 1, 3, 6 and 9), whose records were reviewed. The findings include: 1. Care did not follow a written plan of care established by a physician. Examples include: * Patient #1 was a 94 year old male with a SOC date of 11/7/07. He was currently a patient as of 1/10/08. His diagnosis was osteoarthrosis. His POC (CMS form 485) was signed by the nurse on 11/7/07. The POC included services by the nurse which began on 11/7/07, and services by the PT which began on 11/9/07. The POC which authorized the services was not signed by the physician until 12/20/07. This was 49 days after the SOC date. The DNS was interviewed on 1/10/08 at 3 PM. She confirmed the POC was not signed until 12/20/07. * Patient #3 was a 74 year old male with a SOC date of 12/10/07. He was currently a patient as of 1/10/08. His diagnosis was multiple sclerosis. His POC was signed by the nurse on 12/10/07. The POC included services by the nurse which began on 12/10/07, services by the PT which began on 12/11/07, services by the OT which began on 12/13/07, and services by the MSW which began on 12/19/07. The POC was not	G 158	G158 The Plan of Care will be established by the Director of Clinical Services and/or Nurse Case Manager in a timely manner to be sent to the MD for signature within seven (7) days of start of care and within the five (5) day window prior to the end of the certification period for recertification. The Director of Clinical Services and Nurse Case Manager will keep track of when the Plan of Care is completed and sent out by documenting time and date on an MD Order Tracking Log and then, contacting the Physician if the signed Plan of Care is not in the Patient's chart fourteen (14) days after the order was sent out. This will be completed on 01-Feb-08.	

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G 158	Continued From page 4 signed by the physician until 1/3/08. This was 24 days after the SOC date. The DNS was interviewed on 1/10/08 at 3 PM. She stated the POC was not sent to the MD for signature until 12/26/07. * Patient #6 was a 49 year old female with a SOC date of 5/11/07. Her diagnoses were diabetes and decubitus ulcer. She was currently a patient as of 1/10/08. Her POC for the certification period 11/7/07-1/5/08 was signed by the nurse on 11/5/07. The POC included services by the nurse which began on 11/7/07 during this certification period. The POC was not signed by the physician until 11/29/07. This was 24 days after the certification date. The DNS was interviewed on 1/10/08 at 3 PM. She stated the POC was sent to the MD for signature on 11/9/07 but was not signed until 11/29/07. * Patient #9 was an 83 year old male with a SOC date of 10/18/07. He was currently a patient as of 1/10/08. His diagnosis was total knee replacement. His POC was signed by the nurse on 10/18/07. The POC included services by the nurse which began on 10/18/07 and services by the PA which began on 10/19/07. The POC was not signed by the physician until 11/20/07. This was 33 days after the SOC date. The DNS was interviewed on 1/11/08 at 9:15 AM. She stated the POC was not sent to the MD for signature until 10/26/07. 2. The DNS was interviewed on 1/11/08 at 9:15 AM. She stated the agency did not have a policy which addressed time frames for POCs to be completed and sent to physicians for signature. She also stated the agency did not have a policy which identified actions staff should take when	G 158		

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G 158	Continued From page 5 POCs were not signed and returned in a timely manner.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure that POCs covered all pertinent diagnoses for 3 of 11 patients (#s 3, 6 and 7), whose records were reviewed. The findings include: 1. Patient #3 was a 74 year old male with a SOC date of 12/10/07. He was currently a patient as of 1/10/08. His diagnosis was multiple sclerosis. A physician update written by the nurse, dated 12/20/07, stated "I know that (the patient's spouse) has has been very overwhelmed during this time, and have tried to help her as much as possible during our visits. We are trying to get all of the services in place, with the information that we are getting from the family. I would like to send out a social worker to see if there are resources in the community they can access. I am concerned for (the spouse) and the strain she is under." Social Work visits were made on 12/19/07 and 12/26/07. The social service notes only addressed community resources. They did	G 159	G159 The Director of Clinical Services will orient Nurse Case Managers developing the Plan of Care to cover all pertinent diagnoses, medications and treatments ordered by the Physician. This will include updating the Plan of Care if changes in patient status occur during a certification period or if the Patient is being recertified with any changes to be addressed or updated on Plan of Care. This will include all diagnoses, interventions and goals pertinent to the patient's home health needs. This will be monitored by the Director of Clinical Services or Nurse Case Manager of the patient at the start of care, anytime a change in treatment, condition of medication occurs and at the recertification, if indicated. This will be completed by 01-Feb-08.	

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G 159	Continued From page 6 not address the spouse's anxiety or her difficulties in coping with the patient's illness. The POC was not updated to include the spouse's emotional state to support her ability to care for the patient. The DNS was interviewed on 1/10/08 at 3 PM. She stated the POC did not address the spouse's anxiety or her difficulties in coping with the patient's illness. 2. Patient #6 was a 49 year old female with a SOC date of 5/11/07. Her diagnoses were diabetes and decubitus ulcer. She had an above the knee amputation and a history of skin breakdown. She was currently a patient as of 1/10/08. A physician update, dated 11/5/07, stated "We are continuing treating the wounds/impaired skin, per wound clinic orders, and they are trying to heal. (The patient and spouse) have gone back to poor diet, not positioning her or getting her up and out of bed for more time than the PCS provider is in the home (approximately 2 hours). This has been discussed with (the patient and spouse) and they have also been informed that if they do not start following the care needs that she needs...this will be the last home health episode that she will receive from us." A social worker saw the patient on 11/16/07 and 11/27/07. The social service evaluation on 11/16/07 stated "Pt has a (history) of poor compliance with treatment, meds & diet...Pt also has a (mental illness)-bipolar disorder, but denies any current symptoms or challenges managing the (mental illness)." Her POC for the certification period 11/7/07-1/5/08 did not address the patient's non-compliance nor her diagnosis of bipolar disorder. The POC was not changed following the social workers visits. The social work POC also did not address the patient's non-compliance nor her diagnosis of	G 159		

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G 159	Continued From page 7 bipolar disorder. The DNS was interviewed on 1/10/08 at 3 PM. She stated the POC did not address the patient's non-compliance or mental illness. 3. Patient #7 was a 78 year old male with diagnoses of congestive heart failure and diabetes. His SOC was 7/10/06. He was discharged on 7/10/07. On 5/14/07, he fell and sustained fractures of both legs. The fractures were splinted with braces and the patient returned home on bedrest. The record documented the patient had skin breakdown due to the braces. He also suffered pain from the fractures. The agency obtained orders and took measures to decrease the patients pain and skin breakdown. However, the POC was not changed to address pain control and skin breakdown. The POC for the certification period 7/5/07-9/2/07 did not address these items. Also, after the fall, the patient's spouse became distraught and emotionally fragile. The case manager, interviewed on 1/9/08 at 3:30 PM, stated the spouse was very volatile. She said at times she spent 2 hours in the home because the spouse needed to "vent and cry". The social worker visited the patient and spouse on 5/30 and 6/8/07. The visit notes did not assess the spouse's emotional state or her continued ability to care for the patient. The POC did not address the spouse's emotional state. The case manager confirmed this during the same interview.	G 159		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs.	G 172		

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G 172	Continued From page 8 This STANDARD is not met as evidenced by: Based on review of patient records and agency policies and staff interview, it was determined the agency failed to ensure the registered nurse regularly re-evaluated the nursing needs of 2 of 8 patients (#s 6 and 8), who had received nursing services. The findings include: 1. RN visits were not consistently made to patients who had received nursing services. Examples include: * Patient #6 was a 49 year old female with a SOC date of 5/11/07. Her diagnoses were diabetes and decubitus ulcer. She had an above the knee amputation and a history of skin breakdown. She was currently a patient as of 1/10/08. Her POC for the certification period 11/7/07-1/5/08 stated a nurse was to visit 3 times a week for 8 weeks. The RN visited the patient on 11/7/07 and again on 12/28/07. The other nursing visits were made by an LPN. The RN case manager for this patient was interviewed on 1/10/08 at 3 PM. She stated the patient had cancelled the nursing visits when the RN was scheduled. She confirmed no RN visits had been made during this time period. * Patient #8 was an 86 year old female with a SOC date of 12/14/07. Her diagnosis was total hip replacement. She had an above the knee amputation and a history of skin breakdown. She was currently a patient as of 1/10/08. Her POC for the certification period 12/14/07-2/11/08 stated a nurse was to visit 1 time a week for 9 weeks. The RN visited the patient on 12/14/07 and again on 1/8/08. The other nursing visits were made by an LPN. The RN case manager for this patient was interviewed on 1/11/08 at 9:15 AM. She stated no RN visits had been made during this	G 172	G172 The Director of Clinical Services and the RN Case Manager will visit / assess the Patient at least one (1) time every fourteen (14) days if an LPN is involved in the Patient's care. The RN will supervise the care being provided per the LPN and ensure the Plan of Care is current and responsive to the Patient's needs. The Director of Clinical Services will update the Policy and Procedure Manual to address when the RN needs to make a supervisory visit when an LPN is involved in the Patient's care.	2-1-08

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G 172	Continued From page 9 time period. 2. The DNS was interviewed on 1/11/08 at 9:15 AM. She stated no policy was in place which stated how often an RN needed to assess patients who received nursing services in order to ensure their POCs were current and responsive to patient needs.	G 172		

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the state licensure survey of your agency. The surveyor conducting the licensure visit was Gary Guiles, RN, HFS. Acronyms used in this report include: CMS = Centers for Medicare and Medicaid DNS = Director of Nursing Services LPN = Licensed Practical Nurse POC = Plan of Care RN = Registered Nurse SOC = Start of Care	N 000	RECEIVED FEB 0 1 2008 FACILITY STANDARDS	
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure documentation of effective interchange, reporting, and coordination of patient care had occurred for 3 of 8 patients (#s 3, 6 and 7), who had received multiple services. The findings include: Refer to G144 as it relates to the lack of documentation of coordination of patient care.	N 062	Please refer to G144 Completion date 01-Feb-08	

Bureau of Facility Standards

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137093	A. BUILDING _____ B. WING _____	01/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICARE HOME HEALTH SERVICES, INC	324 S MERIDIAN RD SUITE 10 MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 093	Continued From page 1	N 093		
N 093	03.07024. SK. NSG. SERV. N093 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs; This Rule is not met as evidenced by: Based on review of patient records and agency policies and staff interview, it was determined the agency failed to ensure the registered nurse regularly re-evaluated the nursing needs of 2 of 8 patients (#s 6 and 8), who had received nursing services. The findings include: Refer to G172 as it relates to the lack of re-evaluation the nursing needs by a registered nurse.	N 093	Please refer to G172 Completion date 01-Feb-08	
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Based on review of patient records and agency policies and staff interview, it was determined the agency failed to ensure that care followed a	N 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 152	Continued From page 2 written plan of care established by a physician for 4 of 11 patients (#s 1, 3, 6 and 9), whose records were reviewed. The findings include: Refer to G158 as it relates to the failure of the agency to ensure that care followed a written plan of care established by a physician.	N 152	Please refer to G158 Completion date 01-Feb-08	
N 153	03.07030.PLAN OF CARE N153 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: a. All pertinent diagnoses; This Rule is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure that POCs covered all pertinent diagnoses for 3 of 11 patients (#s 3, 6 and 7), whose records were reviewed. The findings include: Refer to G159 as it relates to the failure of the agency to ensure that POCs covered all pertinent diagnoses.	N 153	Please refer to G159 Completion date 01-Feb-08	